Protocol

Peri-operative Obstructive Sleep Apnea (OSA) Monitoring

Place all Total Joint post-op patients with either known OSA or suspected OSA (STOP-BANG greater than or equal to 3) on continuous Sp O_2 monitoring (centrally monitored or nurse pager/phone alerted).

- Set Sp O_2 alarm at 88%
- Position patients with head of bed elevated greater than 30 degrees or if contraindicated, in lateral position rather than supine unless contraindicated.
- Discontinue basal continuous opiate infusions on PCAs (unless patient is in ICU) and contact physician for alternative orders.
- For inpatients with documented OSA or PACU Respiratory Event, following surgery Respiratory Therapist will:
  Assist patient to use their own CPAP/BIPAP or a hospital owned device, set with home pressures whenever:
  - Level of sedation is greater than 2 (Modified Wilson Scale), or
  - Patient is asleep
- Place patient on hospital-owned APAP device if patient's home device is not available, pressure settings are unknown, or not adequate to maintain oxygen saturation greater than 88% with a respiratory rate greater than 10.
- Use hospital APAP pressure ranges
- For inpatients with **suspected OSA (STOP-BANG score greater than or equal to 3):**
  If saturations are below 88% the RN will call Respiratory Therapy:
  - If RT is going to be delayed, RN will initiate oxygen temporarily while awaiting RT evaluation and titrate per policy to keep Sat greater than 88%.
  - Respiratory Therapy will evaluate the patient for hypoventilation or airway obstruction and:
    - Initiate appropriate positive airway pressure device if indicated
    - Notify Physician if more than 4L O_2 are required to maintain saturation greater than 88%

Note: *Use of supplemental oxygen without assessing for airway obstruction and hypoventilation in a patient with known or suspected OSA is inappropriate, potentially harmful, and can delay recognition of serious patient deterioration.*

If known or suspected sleep apnea patient develops a level of sedation score of 3:

- Hold all opioids (stop PCA) until score is less than 3
  - Call Physician if patient continues to request opioids
- Notify RT to apply positive airway pressure device

If patient develops a level of sedation score of 4, or a respiratory rate less than 10:

- Administer naloxone per Naloxone (Narcan) IV Administration Policy

If patient is unresponsive or not breathing:

- Initiate Code Blue and administer naloxone (Narcan) 0.4 mg (1 mL) IV push, undiluted
- Manually bag ventilate patient until Code Team arrives

Oversedation

Level of Sedation Score (modified Wilson Scale)

1 = Alert, oriented, easy to arouse
2 = Occasionally drowsy, easy to arouse (example: by voice)
3 = Frequently drowsy, difficult to arouse (e.g. sternal rub or painful stimulus), confused
4 = Somnolent, unable to arouse

Narcan Administration Instructions

- Dilute 1 vial of Naloxone as follows:
    a. Expel 1 mL from a 10 mL saline syringe
    b. Draw up 0.4 mg (1 mL) Naloxone into the same saline syringe
- Give 1 mL/min (0.04 mg/min) and repeat every minute until:
    1. Respiratory rate greater than 10/minute
    2. SpO2 greater than or equal to 92%
    3. Level of sedation score is less than 3

Patient Identification:	Sacred Heart Medical Center SH0379 (05/05/11) **Peri-operative Obstructive Sleep Apnea (OSA) Monitoring Protocol** 1 of 1
Clinical Staff: Scan protocol to pharmacy with the order	